1.Last Name	Firs	t Name		MI			Page	_
							nt of Health and Human Servi	
2.Patient Nur	mber		1 1	<u> H</u>		Public Health N	ursing & Professional Develop	ment
3.Date of Birt	th		Month Day	 Vaar		PATIFN	IT VISIT RECOF	5 D
	☐ 1. White	☐ 2. Blac	ck/African Americ			IAIIEN	II VIOII ILLOOI	``
	☐ 3. American Indian/Al		□ 4. As				RR	
	☐ 5. Native Hawaiian/Ot	her Pacific Islander	□ 6. O	her			HC(in)	
		c/Latino Origin?				lemp	BMI O2 sat %	
5.Gender	<u> </u>	Male ☐ 2. Fem	nale	 		BP	Repeat BP	
6.County of R	Residence		_	_				
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C	cc							
Date						. L. Everntie	na Abnaumala Camman	
S inter					ROS wn	Exception	ns, Abnormals, Commer	115
J inter	preter:				Gen			
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	Patient Name, #, or DOB			
	or Attach Patient Label Here			
Labs				
Assessment		Pl	an	
Referrals				
Referrais				
Education				
Return to CI	linic:			
Signature: _		Da	ate:	
		Follow-Up No	tes	
		-		

Date:_

PATIENT VISIT RECORD (DHHS 4059)

This form can to be used for preventive or problem visits.

PATIENT LABEL Attach in this space the computer generated identification label

or emboss in this space the information imprinted on the patient's plastic identification card. When a plastic card or label is not available, manually record the patient's name (last name, first name and middle initial), identification number, date of birth (MM-DD-YYYY), race, ethnicity, gender, and county of

residence.

VITAL SIGNS GRID Document vital signs, etc., as indicated in this grid.

CHIEF COMPLAINT Document chief complaint in the space following cc:

SUBJECTIVE DATA

Document history and other subjective information obtained from the

patient in the space provided. The person taking the history should sign in

the space provided using the legal signature and credentials.

REVIEW OF SYSTEMS Check ($\sqrt{}$) the box by the system if the system is within normal limits. Be

sure to document pertinent negatives for the affected or related systems. Leave box blank and describe any exceptions or abnormals on line

provided.

EXAMINATION Document results of the physical examination in the space provided.

Check $(\sqrt{})$ the box by the system if the system statement is accurate for the exam of that system. If the statement is partially accurate, check $(\sqrt{})$ the box and describe the exceptions, abnormals on the line provided. If the statement is inaccurate, leave the box blank and describe on the line provided. If system is not examined, leave the box and line blank. The person performing the examination should sign in the space provided

using the legal signature and credentials.

LABS Document any labs done prior to or during the visit and their results in

the space provided. Also document labs ordered.

ASSESSMENT Document the assessment or diagnosis in the space provided.

PLAN Document the plan in the space provided.

REFERRALS Document as appropriate.

EDUCATION Document patient education in the space provided.

SIGNATURE The provider of the exam, assessment and plan should sign again on this

side of the form using the legal signature and credentials.

FOLLOW-UP/NOTES Document date of any additional notes or follow-up information

pertinent to this visit in the space provided followed by the legal signature and credentials of the person documenting this information.